STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing and Rehabilitation	3400 Stocker Dr Evansville, IN 47720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plan interventions were implemented for 1 of 2 residents reviewed for falls and 1 of 1 residents reviewed for pressure ulcers. Fall interventions were observed out of place and wound treatment was not completed according to physician orders. (Resident S and Resident N)Findings include: 1. On 1/22/26 at 11:06 A.M., Resident S was observed sitting in her wheelchair in the small tv room next to the nurse's station wearing white socks. The socks did not have nonskid tread on the bottoms.On 1/23/26 at 2:20 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, senile degeneration of the brain and muscle weakness. Resident S's most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident S was not assessed for cognitive impairment because she was rarely or never understood, was independent in eating, and had no falls since the prior assessment on 12/18/25. Resident S refused to complete other Activities of Daily Living (ADLs) during the assessment period.The most current fall risk assessment, dated 12/11/25, indicated that Resident S was at a high risk for falls.A care conference was completed on 11/25/25 at 11:30 A.M. with the resident's family member in attendance. Notes indicated to continue with the current plan of care.A current high-risk for falls care plan, initiated 7/27/16, included, but were not limited to the following interventions:The resident needs a safe environment with: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide rails as ordered; and personal items within reach. This was initiated 7/27/15 and revised on 9/19/25Be sure the resident's call light is within reach and encourage use of it for assistance as needed, initiated 7/27/16 and revised on 9/19/25 Resident to wear nonskid socks at all times as patient allows, dated 8/30/25Resident's A.D. (assistive device) and w/c (wheelchair) to be stored in a safe location to be used with staff assist in order to assist the resident with mobility due to the resident's impaired cognition and decreased ability to sequence mobility safely, initiated 11/24/25The clinical record indicated Resident S sustained falls on the following dates since 1/1/25:3/17/25 at 8:29 A.M. - unwitnessed fall while attempting to self-transfer. The Scoop mattress was added to the plan of care.6/10/25 at 4:30 P.M. - witnessed fall while attempting to self-transfer. A floor pressure alarm was added to the plan of care.8/30/25 at 4:01 P.M. - unwitnessed fall while attempting to self-transfer. Nonskid socks at all times as the patient allows, was added to the plan of care.9/1/25 at 6:45 P.M. - unwitnessed fall while attempting to self-transfer. Hospice to install missing fall interventions was added to the plan of care.10/13/25 at 3:35 A.M. - unwitnessed fall while attempting to self-transfer. Dycem under the fall mat was added to the plan of care.11/24/25 at 5:10 P.M. - unwitnessed fall while attempting to self-transfer. Resident's A.D. and w/c to be stored in safe location to be used with staff assist in order to assist the resident with mobility due to the resident's impaired cognition and decreased ability to sequence mobility safely was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added to the plan of care.12/8/25 at 8:25 A.M. - witnessed a fall while ambulating unassisted. A bed alarm and high floor mat was added to the plan of care. On 1/29/26 at 8:34 A.M., Resident S was observed lying in bed. The bed was positioned in the back on the right side of the room with the resident's feet pointing towards the door. The call light was observed under her bed. Her wheelchair was across from her bed next to a small half dresser in the middle of the left side of the room in the resident's line of sight.During an interview on 1/29/26 at 8:36 A.M., Licensed Practical Nurse (LPN) 16 indicated that Resident S's wheelchair was stored between her recliner, which was positioned at the foot of the bed, and the door because if it was in her line of sight she would try to self-transfer into it. At that time, she indicated that Resident S was capable of using her call light but usually yelled out when she needed help. 2. During an observation on 1/28/26 at 1:41 P.M., RN 8 performed hand hygiene, put a gown and gloves on, and entered Resident N's room. RN 8 pulled the curtain closed, turned Resident N to their left side, used the bed remote to lay the bed down, pulled the bed covers down, and used the pad under Resident N to wipe the paste off of Resident N's coccyx area. RN 8 changed gloves and used a cotton swab to mix collagen and triad (a zinc oxide paste) to Resident N's coccyx area. RN 8 did not cleanse the area before applying the paste. RN 8 did not pause Resident N's continuous tube feeding machine before laying the resident down. On 1/23/26 at 11:30 A.M., Resident N's clinical record was reviewed. Resident N was admitted on [DATE]. Diagnoses included, but were not limited to, chronic respiratory failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/19/25, indicated the resident was rarely or never understood and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. Physician orders included, but were not limited to: Coccyx: cleanse with wound cleanser, pat dry, mix triad and collagen particle together, apply the mixture to the wound bed and leave open to air every day shift for wound Start Date 12/25/25 Diabetisource AC Oral Liquid (Nutritional Supplement) Give 55 ml/hr (milliliters/hour) via PEG (percutaneous endoscopic gastrostomy) Tube (a feeding tube into the stomach) every shift for peg tube continuous feeding Start Date 10/17/25 The current care plan included, but was not limited to: The resident has pressure ulcer or potential for pressure ulcer development related to vegetative state, no mobility, quadriplegia; Administer treatments as ordered and observe for effectiveness Date Initiated: 4/1/25 The resident requires tube feeding related to vegetative state with tracheostomy; Aspiration precautions: Keep head of bed elevated 45 degrees during tube feeding and for one hour after completion of tube feeding. Date Initiated: 4/1/25 During an interview on 1/29/26 at 10:27 A.M., the Infection Prevention Nurse indicated a resident who received continuous tube feeding should not be laid flat and staff should follow treatment orders as ordered by the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/26 at 2:24 P.M., the Administrator provided a policy titled Enteral Nutrition, dated 11/18, that indicated Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. Risk of aspiration may be affected by improper positioning of the resident during feeding. This citation relates to Intake 2707708. 3.1-35(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation record review, and interview, the facility failed to ensure there was an order and care plan for oxygen, tubing was properly dated, and there was an administration posted on door for 1 of 2 residents reviewed for oxygen administration.(Resident W) Finding includes:During a random observation on 1/22/26 at 10:27 A.M., Resident W was observed lying in bed with Oxygen (O2) tubing connected to concentrator with no date on the tubing or water bottle along with the nebulizer, and there was no oxygen administration sign on the door. During a random observation on 1/27/26 at 9:05 A.M., Resident W was observed lying in bed without oxygen on. The nebulizer face mask was observed on the floor and lacked a date on the tubing. Current physician orders lacked documentation of an oxygen order The current clinical record lack documentation of a care plan for oxygen.During an interview on 1/27/26 at 9:30 A.M., Hospice Provider 2 indicated residents on oxygen will have an order for the resident with them but should also have an order with the facility for O2.During an interview on 1/27/26 at 10:30 A.M., Registered Nurse (RN) 4 indicated there should be an order for oxygen for anyone utilizing it.On 1/29/26 at 1:42 P.M., the Administrator provided a current policy Oxygen Administration revised October 2010. The policy indicated .Verify that there is a physician's order.review the resident's care plan to assess for any special needs of the resident. Place an Oxygen in Use sign on the outside of the room entrance door. This citation relates to Intake 2707708. 3.1-47(a)(6)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 3 of 5 residents reviewed for hospitalizations, 1 of 1 residents reviewed for tube feeding, and 1 of 1 residents reviewed for urinary catheter. (Resident D, Resident C, Resident Y, Resident M, and Resident R)Findings include: 1. On 1/23/26 at 2:46 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis and quadriplegia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/20/25, indicated that Resident C was cognitively intact and was dependent on staff (staff does all the work) for all Activities of Daily Living (ADLs). The clinical record indicated the most recent care conference was completed on 11/21/24 at 2:55 P.M. A care conference note, dated 4/15/25, was in progress but had not been completed. On 1/29/26 at 10:12 A.M., the Social Services Director (SSD) provided care conference notes for Resident C dated 4/15/25, 7/8/25, and 9/30/25. All three notes were created in the electronic health record (EHR) and signed on 1/29/26. During an interview on 1/29/26 at 11:55 A.M., the SSD indicated that care conferences were completed every three months. She took notes about the care conference in a notebook and then entered it into the resident's EHR whenever she had the chance. She indicated that she had gotten behind on documentation. 2. On 1/23/26 at 2:30 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic kidney disease and diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated Resident D was cognitively intact, was dependent on staff (staff does all the work) for toileting, weighed 184 pounds (lbs), and had no weight loss. A care conference was completed on 11/11/25 at 1:00 P.M. with the resident in attendance. Notes indicated to continue with the current plan of care. A current risk for weight changes care plan, initiated 8/2/21, included, but was not limited to, the following intervention:Monitor weight and intake. A current noncompliance care plan, initiated 2/20/23, included, but was not limited to, the following intervention:Educate on the possible consequences of refusing care, treatments, medications, etc. and document. Physician orders included, but were not limited to:Weigh patient monthly every one month starting on the first for health monitoring, dated 10/1/25 and discontinued on 1/13/26Monitor weight weekly every Wednesday for health monitoring, 1/14/2026 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A weight summary indicated the following weights had been obtained since 10/1/25:10/1/25 – 184.2 lbs1/1/26 – 166.4 lbs 1/2/26 166.4 lbs1/8/26 – 163.3 lbs The clinical record lacked documented weight refusals. An Interdisciplinary Team (IDT) note, dated 1/7/26 at 1:54 P.M., indicated that the resident had a three percent decrease in weight but no weight was recorded from October to January. The resident needed to be reweighed and an order to obtain weekly weights was given. Resident D's Treatment Administration Record (TAR) for November and December 2025 was reviewed. The monthly weights for November and December were blank and not signed by a staff member. During an interview on 1/29/26 at 1:21 P.M., the Director of Nursing (DON) indicated that Resident D was noncompliant with care, refused to be weighed in November and December, and staff did not document the weight refusals. 3. On 1/28/26 at 11:57 A.M., Resident R's clinical record was reviewed. Resident R was admitted on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/17/25, indicated Resident R was cognitively intact, was dependent on staff (staff do all of the work) for toileting, bathing, and transfers, used oxygen therapy, and had an indwelling catheter. The following physician orders on the electronic medication and treatment administrations (eMAR/eTAR) indicated the following days Resident R's medications or treatments were not administered to the resident or refused by the resident: Lyrica Oral Capsule 100 MG (a pain relief medication) Give one capsule by mouth three times a day for Neuropathy Start Date 7/30/25 10/17/25 9 P.M. 10/22/25 6 A.M. 11/10/25 6 A.M. 12/13/25 6 A.M. 12/13/25 2 P.M. Check blood sugar before meals and at bedtime before meals and at bedtime for monitoring Start Date 7/27/25 10/30/25 9 P.M. 11/6/25 9 P.M. BIPAP Check water level and fill if needed with distilled water every evening shift Start Date 7/22/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/17/25 evening 11/7/25 evening 11/24/25 evening 12/12/25 evening 12/28/25 evening 1/2/26 evening BIPAP clean mask every day shift Start Date 7/23/25 11/24/25 day 12/17/25 day Offer small more frequent meals every shift for gastroparesis Start Date 10/17/25 10/19/25 night 10/21/25 night 11/28/25 night During an interview on 1/30/26 at 9:12 A.M., The Director of Nursing indicated staff who were working during missing eMAR/eTAR administrations stated they provided the medications/treatments, documentation was just missed at the time. 4. On 1/27/26 at 10:21 A.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident M was mildly cognitively impaired and was dependent on staff (staff do all of the work) for toileting, bathing, and transfers. Physician orders included, but were not limited to: Insulin Lispro Subcutaneous Solution Pen injector 100 UNIT/ML (milliliters) Inject as per sliding scale: if 0 - 149 = 0; 150 - 179 = 1; 180 - 209 = 2; 210 - 239 = 3; 240 - 269 = 4; 270 - 299 = 5;300 - 999 = 6 and call MD, subcutaneously before meals Start date 7/16/25 The electronic medication administration record (eMAR) indicated the following days insulin lispro was not administered: 1/2/26 6 A.M. 1/6/26 6 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/8/26 6 A.M. 1/10/26 6 A.M. 1/12/26 6 A.M. 1/13/26 6 A.M. 1/14/26 6 A.M. 1/15/26 6 A.M. 1/17/26 6 A.M. 1/20/26 6 A.M. 1/21/26 6 A.M. 1/22/26 6 A.M. 1/24/26 6 A.M. 1/25/26 6 A.M. During an interview on 1/29/26 at 11:46 A.M., The Director of Nursing indicated the night shift nurse obtained A.M. blood sugars for residents, gave blood sugar results to day shift nurse, and day shift nurse gave insulin at breakfast, sometimes it gets missed in documentation. 5. During an interview on 1/23/26 at 8:27 A.M., Resident Y's responsible party indicated the facility had not invited them to a care conference in the last six to eight months. On 1/23/26 at 2:23 P.M., Resident Y's clinical record was reviewed. Resident Y was admitted on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/5/25, indicated Resident Y was severely cognitively impaired and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. Resident Y's clinical record lacked quarterly care plan conferences since admission. Care plan conferences were requested on 1/29/26 at 8:51 A.M. On 1/29/26 at 10:18 A.M., the social services director provided quarterly care plan conferences on dated 10/28/25 (created on 1/29/26), 6/26/25 (created on 1/29/26), and 5/13/25 (created on 1/29/26). 3.1-50(a)(1) 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were performed on 2 of 2 random observations. Staff observed not utilizing the proper use of PPE of donning and doffing a gown when entering and exiting a room on Enhanced Barrier Protocol (EBP), did not utilize proper hand hygiene and changing gloves when performing tracheostomy suctioning, and locating a glucometer that was not cleaned after use. (Resident N, glucometer) Findings include:Findings include:1. On 1/22/26 at 9:30 A.M., during a random observation of the Insulin Cart, was observed to have a glucometer noted to have 2 spots of blood on the machine.2. On 1/23/2026 at 8:25 A.M., during a random observation of tracheal suction of Resident N, the following was observed:Resident N was noted to be on Enhanced Barrier Protocol due to a tracheostomy.Registered Nurse (RN)11 did not wash hands prior to donning gloves and did not place a gown of Personal Protective Equipment.2 Certified Nurses Assistants (CNA) 12 and 13 entered the room to help pull the resident up and neither donned gowns on for EBP, but they did have gloves. RN 11 paused tube feeding and obtained a tracheostomy care kit.Opened the kit with the same gloves, and also open sterile water container.Removed gloves, washed hands for 60 seconds with soap and water.Placed a sterile glove on the right hand.Touched the trach collar with a sterile gloved hand. Did not remove the glove or wash hands.Touched the suction catheter with a dirty gloved hand. Did not remove the dirty/soiled glove and change to a sterile one and wash hands.Passed a suction catheter into the tracheostomy with the suction on.Cleared the suction catheter with sterile water and proceeded to do 2 more passes with the suction catheter.Put the suction catheter into the container uncurled.Reattached trach collar.Removed gloves and then threw away the contaminated suction catheter. During an interview on 1/22/2036 at 9:30 A.M., Registered Nurse 8 (RN) indicated there should be no blood on glucometers, and the machines are cleaned in between each use.During an interview on 1/23/26 at 9:50 A.M., RN 11 indicated that she should have worn a gown.During an interview on 1/23/26 at 9:55 A.M., CNA 13 and CNA 12 should have worn gowns also.During an interview on 1/29/26 at 10:27 A.M., with the Infection Preventionist, she indicated if residents are in high contact circumstances, such as tracheostomy, there should be a sign for EBP sign on the door and wear proper PPE. She also indicated that if gloves were worn, the gloves should be changed when going from dirty to clean. When asked about cleaning glucometers, she indicated that glucometer should be cleaned after each use.On 1/29/26 at 1:23 P.M., the Administrator provided a policy Handwashing/Hand Hygiene dated October/ 2023. The policy indicated .hand hygiene is indicated with the following: performing an aseptic task.g. immediately after glove removal.Applying and removing gloves should be performed.Perform hand hygiene before applying non-sterile gloves.On 1/29/26 at 2:04 P.M., the Administrator provided a policy Personal Protective Equipment dated October/2018. The policy indicated .The type of PPE required for a task is based on. the type of transmission-based precaution.Personal protective equipment provided to our personnel includes but is not necessarily limited to a. gowns. (disposable, cloth, and/or plastic)); gloves (sterile, non-sterile) .On 1/29/26 at 2:44 P.M., the Administrator provided a current, non-dated policy, Assure Glucometer Platinum Policy. The policy indicated .The meter should be cleaned and disinfected after use on each patient. This citation relates to Intake 2707708. 3.1-18(b)3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment during four random observations. Odors were present in the facility. (Main lobby, Stocker Unit 1, Stocker Unit 2, Conference Room) Findings include: 1. On 1/22/26 at 9:40 A.M., The hallways on Stocker Unit 1 and Stocker Unit 2 had a strong smell of urine. 2. On 1/23/26 at 8:56 A.M., the main lobby, Stocker Unit 1, and Stocker Unit 2 had a strong, pungent smell consistent with sewer gas. 3. On 1/28/26 at 9:05 A.M., the hallway outside of the conference room had a smell consistent with bowel movement. During an interview on 1/29/26 at 11:20 A.M., the Administrator indicated odors in the facility should be controlled by general routine cleaning and staff should increase cleaning in areas that are prone to odors. On 1/29/26 at 1:16 P.M., the Administrator provided a policy titled Environmental, dated 5/17, that indicated The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: pleasant, neutral scents; The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: institutional odors This citation relates to intake 2707708. 3.1-19(f)